L-0000 CHANGES

L-100 REQUIREMENT

Applicants/enrollees are required to report changes to an agency representative when the changes occur.

Federal regulations require a prompt re-evaluation of eligibility when changes are reported. Only the eligibility factors affected by the changed circumstances should be re-evaluated. Other eligibility factors should be considered at the next regularly scheduled renewal.

Exception:
Twelve (12) months continuous eligibility for children under age 19 ** must be explored before terminating a child's eligibility. Refer to H-1910.

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L-200 CHANGES THAT MUST BE REPORTED

The following changes must be reported for the applicant/enrollee or any member of the income/resource unit within ten days of the occurrence if the change applies to the program in which coverage is provided:

- source of income,
- amount of income,
- changes in household composition,
- birth,
- death,
- pregnancy or end of pregnancy,
- value or ownership of a resource, including the acquisition of a new resource,
- change of address,

- receipt of a lump-sum payment or settlement,
- admission to or discharge from an institution, including a LTC facility,
- change of Case Management agency,
- school attendance of a LIFC certified child age 18 or over,
- other medical insurance coverage and the premium amounts,
- information regarding an absent parent,
- disability and
- the responsible person of an LTC applicant/enrollee.

LTC Only

The LTC facility is required to report to the agency:

- admissions, transfers, deaths, and discharges, and
- any changes in the applicant/enrollee's income or resources of which facility personnel becomes aware.

HCBS Only

The Case Management agency is required to report to the Medicaid agency:

- admissions, deaths, discharges, and transfers (transfers to another case management agency, and temporary absence of waiver services due to placement in a hospital, nursing facility, respite center or other medically necessary program with the intent to return to waiver) and,
- any changes in the applicant/enrollee's income or resources of which provider personnel becomes aware.

Note:
Temporary absence of Home and Community Based Waiver services may require type certification to be closed in MEDS to allow the enrollee to be certified in a different type certification. A discharge for temporary absence does not mean that the enrollee's

eligibility for waiver services has been terminated.
Office of Aging and Adult Services (OAAS) or Office for Citizen's with Developmental Disabilities (OCDD) is required to report to the Medicaid agency:

- permanent discharge from the Waiver program (loss of waiver slot).

L-300- 400 RESERVED

L-500 ACTION ON CHANGES

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SSI Only

Action on changes to SSI-Medicaid cases is taken only after notification from SSA. The Agency receives information about changes to SSI records via the SDX interface. **

Changes reported to the agency which may affect eligibility of SSI cases should be sent to SSA via Form SSI.

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LTC Only

Upon receipt of notice from an LTC facility advising of discharge, review the case record and determine correct case action.

When an enrollee receiving an SSI payment while in an LTC facility is discharged to a non-institutionalized setting:

- notify the enrollee/responsible person, facility, and OCDD or OAAS Regional office (depending on the waiver program) of termination of the vendor payment to the LTC facility,

- change the type case to a type for a non-institutionalized individual (Type case 78),

- notify SSA of the discharge.

When an enrollee who is eligible for SSI payments (but was not receiving while in a LTC facility) is discharged:

- send adequate notice of termination of vendor payment to the enrollee/responsible person, the facility, and OCDD or OAAS Regional office (depending on type facility).

- change the type case to a type for a non-institutionalized individual (Type case 78,approval code 09), and

- refer the enrollee/responsible person to SSA for cash benefits

When an enrollee who is not SSI eligible is discharged to a Medicaid-certified facility, (acute care hospital or rehabilitation center) to receive Medicaid-payable services:

- Give adequate notice to the enrollee/responsible person and the facility:

  – of termination of vendor payment to the LTC facility,

  – that eligibility for medical services will end when the enrollee is discharged from the facility, unless he enters another LTC facility, and

  – that the enrollee/responsible person shall report discharge from the facility on the date of discharge.

- Review the enrollee's status at least monthly until discharge.

- Determine continued eligibility for medical assistance when the enrollee is discharged from the facility.

  – If discharged back to an LTC facility, determine eligibility in the LTC facility. Refer to H-820, LTC—C-Related, or H-830, LTC—SSI-Related.

  – If discharged to a non-institutionalized setting, consider eligibility in all other programs. If ineligibility in all programs is established, send advanced notice of closure and close the case at expiration of the advance notice period.

When an enrollee who is not receiving nor is eligible to receive SSI payments is discharged from LTC facility:

- send adequate notice of termination of vendor payment to the enrollee/responsible person, the facility, and OCDD or OAAS Regional office (depending on type facility),

- consider eligibility for Medicaid in other programs, and

- if ineligibility in all programs is established, send advance notice of closure, and close the case at the expiration of the advance notice period.

Note:
An enrollee between the ages of 21 and 65 is not eligible for Medicaid-payable services in a mental hospital.

HCBS Only

Upon receipt of notice advising of the discharge of a waiver enrollee, review the discharge to determine if it is a temporary absence of waiver services or a permanent discharge from the Waiver program (loss of waiver slot/opening). OCDD or OAAS must make the determination of a permanent discharge from the Waiver program (loss of waiver slot/opening).

Temporary Absence from Waiver Services

When a waiver enrollee is temporarily discharged to a Medicaid-certified facility to receive Medicaid-payable services with the intent to return to HCBS:

- Give adequate notice to the enrollee/responsible person and the Case Management agency:

  – of termination for waiver services to the Case Management agency,

  – that eligibility for medical services will end when the enrollee is discharged from the facility, unless he\she begins HCBS, and

  – that the enrollee/responsible person shall report discharge from the facility on the date of discharge.

- Review the enrollee's status at least monthly until discharge.

- Determine continued eligibility for medical assistance when the enrollee is discharged from the facility.

- If discharged back to HCBS, determine eligibility in HCBS. Refer to H-900.

- If discharged to a non-institutionalized setting, consider eligibility in all other programs. If ineligibility in all programs is established, send advance notice of closure and close the case at expiration of the advance notice period.

Permanent Discharge from the Waiver program:

When a waiver enrollee receiving SSI payments while receiving HCBS is discharged by OCDD or OAAS and is eligible to remain in a non-institutionalized setting:

- notify the enrollee/responsible person, Case Management agency, OCDD or OAAS Regional office (depending on waiver program) of termination of the waiver service payment for HCBS,

- change the type case to a type for a non-institutionalized individual (Type case 78).

When a waiver enrollee who was not receiving SSI payments while receiving HCBS is discharged by OCDD or OAAS (depending on waiver program) and is not eligible for SSI in a non-institutionalized setting:

- send adequate notice of termination of waiver services payment to the enrollee/responsible person, the Case Management agency, and OCDD or OAAS Regional office (depending on waiver program).

- consider eligibility for Medicaid in other programs, and

- if ineligibility in all programs is established send advance notice of closure and close the case at the expiration of the advance notice period.

Note:
An enrollee between the ages of 21 and 65 is not eligible for Medicaid-payable services in a mental hospital.

L-600 ADEQUATE NOTICE

Adequate notice is sent no later than the date the action is taken.

The following case actions require only adequate notice:

- closure upon death of the only enrollee or payee, when death has been verified (Form 148, copy of obituary, mail returned from post office marked “Deceased”, or other reliable evidence), even if the actual date of death cannot be verified,

- removal of enrollee upon death, if verified (see above),

  Note: If death cannot be verified, advance notice is required before closure or removal.

- closure when the enrollee's whereabouts are unknown and agency mail directed to him has been returned by the post office indicating no known forwarding address,

  Exception:
  Do not terminate a child's eligibility before exploring twelve (12) months continuous eligibility. Refer to H-1910.

- closure when SDX provides information that the enrollee has moved out of the state or it is documented that the enrollee has been certified in another state,

- removal of an enrollee from one case and certification in another case with no change in benefits or an increase in benefits,

- increase or decrease in the amount of patient liability,

- addition of a recipient to a certification,

- increase or decrease in the amount of MPP premium liability,

- termination of vendor payment to a LTC Facility or Case Management agency when other Medicaid benefits continue,

  Exception:
  When termination of vendor payment is the result of transfer of resource provisions, send advance notice.

- open/close certifications (Notice of decision serves as the adequate notice),
- mass changes that do not result in closure, or
- changes that require advance notice of adverse action, when the enrollee waives in writing his right to advance notice.

L-700 ADVANCE NOTICE

All case changes that result in closure of Medicaid benefits and are not identified as requiring adequate notice require advance notice.

Advance notice gives the enrollee a specific period in which to:

- appeal the proposed action and have benefits continued until a fair hearing decision is made, or
- provide verification that the change should not be made.

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Reminder:
Twelve (12) months continuous eligibility for children under age 19 ** must be explored before terminating a child's eligibility. Refer to H-1910.

L-800 MASS CHANGES

A mass change occurs when the federal or state government initiates a change in a program or a requirement that affects all cases with certain characteristics.

Mass changes include:

- cost-of-living benefit adjustments (COLAs) for RSDI, SSI, and other Federal benefits, and
- changes in eligibility criteria based on legislative or regulatory actions.

L-900 APPEAL REQUESTS

Adequate Notices

If the enrollee requests a fair hearing after receipt of an adequate notice, do not reinstate benefits unless directed to do so by the Appeals Section.

Advance Notices

Do not take the proposed action if the enrollee requests a fair hearing during the advance notice period.